# COVID-19 DAILY SCREENING TOOL

Please complete this tool every morning before sending your child to school. If you answer "yes" to any of the questions below, your child must stay home from school and you should follow-up with your health care provider as needed.

| My Child… | YES | NO |
|---|---|---|
| Has **one** or more of the following:<br>• Cough (for students with asthma/allergies – look for a change in your child's cough from normal)<br>• New lack of smell or taste<br>• Shortness of breath<br>• Difficulty breathing | | |
| Has **two** or more of the following:<br>• Fever (100 degree Fahrenheit or higher)<br>• Chills<br>• Sore throat<br>• Muscle pain<br>• Runny nose/congestion<br>• Nausea<br>• Vomiting<br>• Headache<br>• Diarrhea | | |
| Has taken medicine this morning to reduce a fever (example: Tylenol or Ibuprofen) | | |
| Can answer yes to **one** or more of the following:<br>• Has been in close contact (within 6 feet for 15 or minutes or more) with someone with confirmed COVID-19.<br>• Traveled to or lives where the local, Tribal, territorial, or state health department is reporting large numbers of COVID-19 cases as described in the Community Mitigation Framework.<br>• Lives in an area of high community transmission (as described in the Community Mitigation Framework) while the school remains open. | | |

**PLEASE CONTACT YOUR SCHOOL NURSE [(717)741-0820 EXT. 5124] OR ADMINISTRATOR WITH ANY QUESTIONS OR CONCERNS.**

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